

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13156

## CERTIFICATE OF DEATH

13154

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Preston</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland,</u>				c. LENGTH OF STAY IN 1b <u>4 Months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Evans Nursing Home</u>				d. STREET ADDRESS <u>R. D.</u>			
3. NAME OF DECEASED (Type or print) First <u>W.</u> Middle <u>Scott</u> Last <u>Barnes</u>				4. DATE OF DEATH Month <u>December</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 4, 1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired School Teacher, Public Schools,</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>J. P. Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Harshberger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>E. G. Harned</u> Address <u>Brandonville, W. Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Cardiovascular Disease 10 years</u> DUE TO (c) <u>and Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>57</u> to <u>December 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>November 15</u> , 19 <u>57</u> , and that death occurred at <u>6:10 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herbert H. Leighton</u> M.D.				ADDRESS (Street, city or town, state) <u>77 Oak St. Oakland Md.</u>			
DATE SIGNED <u>1 Dec 57</u>							
PHYSICIAN'S NAME (Type) <u>Herbert H. Leighton, M. D.</u>				<u>Oakland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/3/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shady Grove Cemetery near Brandonville, W. Va.</u>		22d. LOCATION (City, town, or county) (State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. G. Harned</u>				ADDRESS <u>Brandonville, W. Va.</u>		24a. RECEIVED BY REGISTRAR <u>12/3/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Julia C. Brown R.R.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 4 1957

RECEIVED

# 1 13157 Item 8 Film 0223 12-30-57 et MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

13157 6

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park</b> c. LENGTH OF STAY IN b <b>22 years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route # 1</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mountain Lake Park, x2 (Rural)</b> d. STREET ADDRESS <b>Route # 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lucinda S. Biser</b>		4. DATE OF DEATH <b>December 12, 1957.</b> Month <b>12</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 4, 1868</b>
9. AGE (In years lost birthday) <b>89</b> yrs.		IF UNDER 1 YEAR: Months <b>11</b> Days <b>8</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Egdon, West Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Aaron Fike</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Rudolph</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Elza Biser, Mt. Lake Park, Maryland. Route #1</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>19 Oct., 1957</b> , to <b>9 Nov., 1957</b> , that I last saw the deceased alive on <b>9 Dec., 1957</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above. (12 Dec. 57) ADDRESS (Street, city or town, state) <b>Oakland, Maryland.</b> DATE SIGNED <b>December 13, 1957</b>			
ACTUAL SIGNATURE <b>A E Mance</b> M.D.		PHYSICIAN'S NAME (Type) <b>Andrew E. Mance, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 14, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Egdon Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Egdon, West Virginia.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Terra Alta, W. Va.</b>		24a. REC'D BY REGISTRAR <b>12/14/57</b> 24b. REGISTRAR'S SIGNATURE <b>Julia C. Rowan</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

IN REPLY TO STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

DATE OF DEATH

PLACE

CAUSE

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

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DATE OF DEATH

PLACE OF DEATH

BUREAU V. B.

DEC 28 1911

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13158**  
**CERTIFICATE OF DEATH**

13156

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kempton</b>			c. LENGTH OF STAY IN 1b <b>30 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Kempton</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Gertrude</b> Middle <b>May</b> Last <b>Dragovich</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>2</b> Year <b>1957</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 26, 1902</b>		9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Stanley Perchan</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Lamb</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Donald G. Dragovich, Barborton, O.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aortic valve insufficiency</b> DUE TO (c) <b>Arteriosclerotic Cardiovascular Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr.</b> <b>Unknown</b> <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 24, 1957</u> to <u>December 1, 1957</u> that I last saw the deceased alive on <u>November 16, 1957</u> and that death occurred at <u>12:10 A.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Herbert H. Leighton</i> M.D.		ADDRESS (Street, city or town, state) <b>77 Oak Street, Oakland, Md.</b>		DATE SIGNED <b>Dec 5, 1957</b>			
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M.D.</b>		<b>Oakland, Maryland</b>		<b>Dec. 5, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>12/5/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Thomas, W.Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.A.A. Dunbar</i>				ADDRESS <b>Thomas, W.Va.</b>		24a. REC'D BY REGISTRAR DATE <b>12/5/57</b>	
				24b. REGISTRAR'S SIGNATURE <i>Julius [illegible]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

BUREAU V. S.

DEC 23 1957

RECEIVED

13159

## CERTIFICATE OF DEATH

13157

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett, Co.,</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penna/</u> b. COUNTY <u>Somerset Pa.</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Salisbury, Pa.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Meyersdale, Pa., R.D.# 3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D.# 1 Salisbury, Pa.</u>				d. STREET ADDRESS <u>R.F.D.# 3 75X-3</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Faidley</u> Last <u>Faidley</u>				4. DATE OF DEATH Month <u>12</u> - Day <u>18</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22, 1885</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public</u>		11. BIRTHPLACE (State or foreign country) <u>Somerset Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>Alexander Faidley</u>				14. MOTHER'S MAIDEN NAME <u>Malinda Lichty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>163-14-2474</u>		17. INFORMANT <u>Mrs. Galen Maust- R.D.# 1, Salisbury, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac decompensation</u> DUE TO (c) <u>arteriosclerotic heart disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma upper palate</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>57</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov 18</u> , 19 <u>57</u> , to <u>Dec 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 16</u> , 19 <u>57</u> , and that death occurred at <u>11:15 P.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Leonard L. Rock</u> M.D. <u>209 North St</u>				<u>12/19/57</u>			
PHYSICIAN'S NAME (Type) <u>L.L. Rock, M.D.</u>				<u>Meyersdale, Pa.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-21-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Ch. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>R.F.D.# 3, Meyersdale, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. P. Konhans</u>				ADDRESS <u>Meyersdale, Pa.</u>		24a. REC'D BY REGISTRAR <u>Jan 6 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>U. H. Kieduch</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. S.

JAN 6 1953

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13:60  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

13158

Reg. Dist. No. 166

1. PLACE OF DEATH o. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegheny</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park,</b>				c. LENGTH OF STAY IN 1b <b>11 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kiser Nursing Home</b>				d. STREET ADDRESS <b>not known</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Cooper</b> Last <b>Flora</b>				4. DATE OF DEATH Month <b>December</b> Day <b>18,</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 10, 1862</b>	
9. AGE (In years last birthday) <b>95</b>		IF UNDER 1 YEAR Months <b>10</b> Days <b>2</b> Hours <b>2</b> Min.		IF UNDER 24 HRS. Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>----</b>		17. INFORMANT <b>Harry Kiser</b> Address <b>Mt. Lake Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SENILITY</b> <b>794X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Starvation</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Oakland, Md.</b>				20g. (County) <b>Oakland</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>12-7-53</b> , to <b>12-17-57</b> , that I last saw the deceased alive on <b>12-17-57</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James H. Feaster Jr.</b> M.D. <b>58-2-4-34-6A-1-1-1</b>				DATE SIGNED <b>12-18-57</b>			
PHYSICIAN'S NAME (Type) <b>James H. Feaster Jr.</b>				ADDRESS <b>Oakland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/20/1957</b>		22c. NAME OF CEMETERY OR CREMATOR <b>Warfords Presbyterian</b>		22d. LOCATION (City, town, or county) (State) <b>Warfordsburg, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b>				ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>12/19/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Julia K. Rowan</b>							

CERTIFICATE OF DEATH

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RECEIVED

## INSTRUCTIONS

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13159

13161

## CERTIFICATE OF DEATH

Reg. Dist. No. 166

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Garrett</u>		STATE <u>Maryland</u>		COUNTY <u>Garrett</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rural Deer Park,</u>		LENGTH OF STAY (in this place) <u>79 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Deer Park,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7 Mi. So. Deer Park, Md.</u>				STREET ADDRESS (If rural give location) <u>7 Mi. So. Deer Park, Md.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Elmer</u> (First) <u>Harvey</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>Dec.</u> (Day) <u>28,</u> (Year) <u>57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>August 15, 1878</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Thomas K. Harvey</u>				14. MOTHER'S MAIDEN NAME <u>Susan Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If Yes, give year or dates of service)</u>		17. INFORMANT & ADDRESS <u>F. D. Mrs. Elmer Harvey Deer Park, Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Pulmonary Edema Acute</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular Disease</u>				<u>15 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Diarrhea</u>				<u>2 days</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>March 19 57</u> , to <u>Dec 28, 1957</u> , that I last saw the deceased alive on <u>Dec 20, 1957</u> , and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Hubert H. Leighton</u>		DATE THEREOF <u>12/31/1957</u>		NAME OF CEMETERY OR CREMATORY <u>White Church Cemetery</u>		LOCATION (City, town, or county) (State) <u>Garrett County, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Julia G. Rowan</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Leighton</u>		ADDRESS <u>Oakland, Md.</u>	

J. V. E.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar or prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13162

## CERTIFICATE OF DEATH

13162

Reg. Dist. No. 66

1 PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>WEST VIRGINIA</b> b COUNTY <b>GORMAN</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CALLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GORMANIA</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>ROUTE #1</b>	
3. NAME OF DECEASED (Type or print) First <b>PERRY</b> Middle <b>WILLIAM</b> Last <b>LEWIS</b>		4. DATE OF DEATH Month <b>12</b> Day <b>25</b> Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 16, 1902</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COAL MINER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COAL MINING</b>	
11. BIRTHPLACE (State or foreign country) <b>SWALLOW FALLS, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ELORY LEWIS</b>		14. MOTHER'S MAIDEN NAME <b>STELLA LEE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO <b>232-09-5386</b>	
17. INFORMANT <b>UNKNOWN</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Retum</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>6-11-57</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 24, 1957</b> , to <b>Dec 25, 1957</b> , that I last saw the deceased alive on <b>Dec 25, 1957</b> , and that death occurred at <b>5:15 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Andrew E. Mance</b> M.D.		ADDRESS (Street, city or town, state) <b>Oakland Md</b> DATE SIGNED <b>26 Dec 57</b>	
PHYSICIAN'S NAME (Type) <b>Andrew E. Mance, M. D.</b>		<b>Oakland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>12/27/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>	22d. LOCATION (City, town or county) (State) <b>near Gorman, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Reighton</b>		ADDRESS <b>Oakland, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 12/27/1957</b>		24b. REGISTRAR'S SIGNATURE <b>Julia A. Rogers</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 7 FilmG244 1-13-54  
13163  
CERTIFICATE OF DEATH

13161  
166

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND MD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CUPPETS NURSING HOME</b>		e. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First <b>PEARL</b> Middle <b>S.</b> Last <b>RALEY</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>30</b> Year <b>1957</b>	
5 SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL-20-1884</b> 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>WILLIAMS PORT PA U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM G. MILLER</b>		14. MOTHER'S MAIDEN NAME <b>ANNA E. CARPENTER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs Eva Poling Richmond Virginia</b>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> DUE TO <b>Metastatic Carcinoma of Lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Breast</b> (c) <b>2 Years</b> <b>4 Years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Dec 21</b> , 1957, to <b>Dec 30</b> , 1957, that I last saw the deceased alive on <b>Dec 28</b> , 1957, and that death occurred at <b>12:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert H. Leighton</b> M.D.		ADDRESS (Street, city or town, state) <b>77 Oak St. Oakland, Md.</b> DATE SIGNED <b>3/1/58</b>	
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M.D.</b>		<b>Oakland, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>DEC-31-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL MAUSOLEUM</b>	22d. LOCATION (City, town, or county) (State) <b>CUMBERLAND MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Stearns Funeral Home, Cumberland, Md.</b>		24a. RECEIVED BY REGISTRAR <b>Julius A. Rowan</b> DATE <b>12/30/57</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13164  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

13162  
Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>GARRETT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAIKLAND</u>				c. LENGTH OF STAY IN TB <u>17 DAYS</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POTAL * CAIKLAND</u> X/				d. STREET ADDRESS <u>Route 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GARRETT COUNTY TUBERCULAR HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LEMO</u> Middle <u>N</u> Last <u>SCHROCK</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-2-11</u>	9. AGE (In years last birthday) yrs. <u>16</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>CAIKLAND, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>NOAH D. SCHROCK</u>				14. MOTHER'S MAIDEN NAME <u>CORA BURKICIDEL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. NOAH D. SCHROCK</u> Address <u>ROUTE 2 OAKLAND, MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral</u> due to <u>592x</u> DUE TO <u>Malignant Hypertension</u> due to <u>8 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephritis Chronic</u> due to <u>10 years</u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>40 weeks</u> <u>8 years</u> <u>10 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 28</u> , 19 <u>47</u> , to <u>Dec 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>27 Dec</u> , 19 <u>57</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Oakland Md</u> DATE SIGNED <u>28 Dec 57</u>							
ACTUAL SIGNATURE <u>Andrew E. Mance</u> M.D.		PHYSICIAN'S NAME (Type) <u>ANDREW E. MANCE, M. D.</u> <u>OAKLAND, MARYLAND</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12/30/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Slabaugh Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Gortner, Garrett Co., Id.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Leighton</u> ADDRESS <u>Oakland, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>12/30/1957</u>		24b. REGISTRAR'S SIGNATURE <u>Julia A. Brown</u>	

U. S.

1903

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1903



CERTIFICATE OF DEATH

Reg. Dist. No.

131636

13165

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY CATHERINE STANTON</b>				4. DATE OF DEATH Month Day Year <b>DEC. 23 1957</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE-16-1876</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>HOWESVILLE W.VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY BARLOW</b>				14. MOTHER'S MAIDEN NAME <b>SARAH ARMS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>ROBERT STANTON</b>		Address <b>OAKLAND MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>10 years</b>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 17, 1955</b> , to <b>Dec. 23, 1957</b> , that I last saw the deceased alive on <b>Dec. 23, 1957</b> , and that death occurred at <b>11:35 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. E. Mance</b>				ADDRESS (Street, city or town, state) <b>101 3rd St - Oakland Md.</b>			
PHYSICIAN'S NAME (Type) <b>A. E. MANCE, M.D.,</b>				DATE SIGNED <b>101 3RD. St., Oakland, Md.,</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>DEC-27-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>OAKLAND CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>OAKLAND MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emory Bolden</b>				ADDRESS <b>OAKLAND MD</b>		24a. REG'D BY REGISTRAR <b>12/27/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Julius G. Rowan</b>			

ROMANO V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13'66 CERTIFICATE OF DEATH

131646

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>MARYLAND</b> b COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL</b> <b>OAKLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>STAR ROUTE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>VIRGINIA</b> Middle <b>THAYER</b> Last <b>THAYER</b>		4. DATE OF DEATH Month <b>12</b> Day <b>12</b> Year <b>1957</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 25, 1864</b>
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOSEPH WELCH</b>		14. MOTHER'S MAIDEN NAME <b>MARY JANE WAGNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>J.P. THAYER</b>	
17. INFORMANT <b>STAR ROUTE - OAKLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO <b>4 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Vascular Disease</b> DUE TO <b>Unknown</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>0</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 10, 1957</b> to <b>Dec 12, 1957</b> that I last saw the deceased alive on <b>Dec 12, 1957</b> and that death occurred at <b>4:30 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert H. Leighton</b> M.D.		ADDRESS (Street, city or town, state) <b>77 Oak St. Oakland, Md.</b>	
DATE SIGNED <b>Dec 12, 1957</b>			
PHYSICIAN'S NAME (Type) <b>HERBERT LEIGHTON, M.D.</b>		<b>OAKLAND, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>BURIAL</b>	<b>DEC-15-1957</b>	<b>THAYERVILLE CEMETERY</b>	<b>THAYERVILLE NEAR OAKLAND, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emory Bolden</b>		ADDRESS <b>OAKLAND MD</b>	
24a. REC'D BY REGISTRAR DATE <b>12/15/57</b>		24b. REGISTRAR'S SIGNATURE <b>Julius A. Power JR</b>	

U.S. A. 1000

1000

13165

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

13'67

## CERTIFICATE OF DEATH

Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <b>Garrett</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>Friendsville</b> TOWN <b>Friendsville</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Own home</b>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Garrett</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>Friendsville</b> TOWN <b>Friendsville</b> STREET ADDRESS <b>---</b>	
3. NAME OF DECEASED (First) (Middle) (Last) <b>George J VanSickle</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Dec 21 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>12/4/1881</b>
9. AGE last birthday <b>76</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>
11. BIRTHPLACE (State or foreign country) <b>Friendsville Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George H VanSickle</b>		14. MOTHER'S MAIDEN NAME <b>XXXXXXXX Elisabeth Sisler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY No. <b>---</b>	
17. INFORMANT AND ADDRESS <b>---</b>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1. Immediate cause

(a)...

**Squamous cell carcinoma of face**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)...

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

**12-24-56**

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

## 20. AUTOPSY?

Yes ☐ No ☐TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **10-16**, 19**56**, to **8-7**, 19**57**, that I last saw the deceasedalive on **8-7**, 19**57**, and that death occurred at **---** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**Joseph Alvarez****M. D.****Oakland, Md.****Dec. 23, 1957**

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF  
**12/31/57**NAME OF CEMETERY OR CREMATORY  
**Blooming Rose Cem-**LOCATION (City, town, or county)  
**Garrette MD**

(State)

DATE REC'D BY LOCAL REG.  
**Dec 23, 1957**REGISTRAR'S SIGNATURE  
**Mrs Ruth T. ...**

24. FUNERAL DIRECTOR

ADDRESS  
**Harold Brandonville W Va**

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

DEC 27 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13168

CERTIFICATE OF DEATH

13166

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b> <b>MD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>OAK ST.</b> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOSEPH</b> First <b>A.</b> Middle <b>WELLING</b> Last		4. DATE OF DEATH <b>DEC.</b> Month <b>29</b> Day <b>1957</b> Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY-30-1882</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>OAKLAND MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DAVID WELLING</b>		14. MOTHER'S MAIDEN NAME <b>NANCY KAMPHFER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Jesse Welling</b> Address <b>Oakland MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Paralysis</b> DUE TO <b>HYPERTENSION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Heart Failed</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 Year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-25</b> , 19 <b>57</b> to <b>12-29</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Dec 29</b> , 19 <b>57</b> , and that death occurred at <b>12 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J W W WENZEL</b> M.D. <b>Oakland</b>		ADDRESS (Street, city or town, state) <b>Oakland MD</b> DATE SIGNED <b>12/31/57</b>	
PHYSICIAN'S NAME (Type) <b>J W W WENZEL,</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JAN-1-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>OAKLAND CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>OAKLAND MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emory Briden</b> ADDRESS <b>OAKLAND MD</b>		24a. REC'D BY REGISTRAR <b>12/31/57</b> 24b. REGISTRAR'S SIGNATURE <b>John H. Brown</b>	

B A OUTSIDE

COPIES

10-1-1964

13169

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Accident, Md.</b>				c. LENGTH OF STAY IN 1b <b>2 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HARRIET</b> Middle <b>WHORTON</b> Last <b>WHORTON</b>				4. DATE OF DEATH Month <b>December</b> Day <b>1</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 4, 1862</b>	
9. AGE (In years last birthday) <b>95 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Allegheny Co., Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Henry Kifer</b>		14. MOTHER'S MAIDEN NAME <b>Mary unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Carl Whorton, Accident, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>10 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>45 mins.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October, 1956</b> , to <b>Dec 1, 1957</b> , that I last saw the deceased alive on <b>Nov 18, 1957</b> , and that death occurred at <b>3:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Milton Tepper</b> M.D. <b>no # Maple St Friendsville, Md Dec 4, 1957</b> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/4/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glendale</b>		22d. LOCATION (City, town, or county) (State) <b>Flintstone, Allegheny Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Don J Newman</b>				ADDRESS <b>Grantsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 18 '57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Alb Leach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the regular prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

BUREAU V. S.

DEC 18 1957

RECEIVED



13170

CERTIFICATE OF DEATH

Reg. Dist. No.

166

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>				c. LENGTH OF STAY IN 1b <b>20 Minutes</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett County Memorial Hospital</b>				e. STREET ADDRESS <b>Route # 2</b>			
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Wiley</b>				4. DATE OF DEATH Month <b>December</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 11, 1957</b>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours Min. <b>20</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <b>Oakland, Maryland</b>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Ray Ulysses Wiley</b>				14. MOTHER'S MAIDEN NAME <b>Stella Frances Bittinger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>"Mother" Mrs. Stella Frances Wiley</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO <b>Immature Development (1lb. 4oz)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Delivery at 6 months gestation</b> (c) <b>20 minutes</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Dec 11, 1957</b> to <b>Dec 11, 1957</b> , that I last saw the deceased alive on <b>Dec 11, 1957</b> , and that death occurred at <b>8:45 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Herbert H. Leighton</b> M.D.				ADDRESS (Street, city or town, state) <b>77 Oak Street, Oakland, Md.</b>			
DATE SIGNED <b>Dec 11, 1957</b>							
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M. D.</b>				<b>Oakland, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>12/11/57</b>		<b>GRANTSVILLE</b>		<b>GRANTSVILLE GARRETT Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Don J. Newman</b> ADDRESS <b>121</b>				24a. REC'D BY REGISTRAR DATE <b>12/11/57</b>		24b. REGISTRAR'S SIGNATURE <b>John A. Brown</b>	

WEST VIRGINIA DEPARTMENT OF HEALTH - BUREAU OF HEALTH  
 CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Race		7. Color		8. Religion		9. Marital status		10. Occupation		11. Education		12. Date of death		13. Place of death		14. Cause of death		15. Manner of death		16. Signature of physician		17. Signature of registrar		18. Signature of informant		19. Date of registration		20. Place of registration	

BUREAU V. S.

DEC 28 1957

RECEIVED